**(Insert Name/Address/Email Address and Telephone Number of the LME-MCO**

**Notice of Resolution**

**Outcome of Medicaid Reconsideration Review-Upheld**

**(Date of Letter)**

VIA TRACKABLE MAIL: {Fill from Tracking Number}

|  |  |
| --- | --- |
| NAME or GUARDIAN of NameStreetCity, NC zip code | MID: DOB:County of Origin: Waiver:  |

Dear Name or GUARDIAN of Name:

(**Insert Name of LME-MCO)** is responsible for approving Medicaid authorizations for mental health, intellectual/ developmental disabilities, and/or substance use services.  **(Insert Name of LME-MCO)** was asked to complete a Reconsideration Review of the decision to deny some or all of your request for the service and dates listed below.

After completing this Reconsideration Review, **(Insert Name of LME-MCO)** decided to ***UPHOLD*** the original decision. This means that **(Insert Name of LME-MCO)**’s decision will remain and no more dates and units will be approved for this authorization request than were originally approved. This notice explains why this decision was made and tells you how to appeal if you disagree.

|  |  |
| --- | --- |
| **Service Originally Requested** | D**ates/Units Originally Requested** |
| (Insert Service Originally Requested) | (Insert Dates/Units Originally Requested) |

|  |  |  |
| --- | --- | --- |
| **Service Originally Approved** | **Dates/Units Originally Approved** | **Dates/Units Originally Denied, Partially Denied, Terminated, Reduced or Suspended** |
| (Insert Service Originally Approved) | (Insert Dates/Units Originally Approved) | (Insert Dates/Units Originally Denied, Partially Denied, Terminated, Reduced or Suspended) |

Through a peer review process, **(Insert Name of LME-MCO)** decided the following:

|  |  |
| --- | --- |
| **Date of (Insert Name of LME-MCO’s Reconsideration Review Decision** | **Reconsideration Review Decision** |
| **(**Insert Date of Reconsideration Review Decision) | Denial; Partial Denial, Termination, Reduction or Suspension Decision Upheld |

**Background Information**

1. **Date Reconsideration Review was completed: (Insert Review Date)**
2. **Documents Reviewed: (Insert documents reviewed in Reconsideration Review)**
3. **Clinical Coverage Policies Reviewed: (Insert Clinical Coverage Policies cited in Reconsideration Review)**

 **Reason decision was upheld:** reason should cite **specific** regulations, statute or medical policy supporting the decision being upheld. If upholding decision based on policy, include **specific** reference to policy criteria and what criteria is not met and the facts that support criteria not being met.

1. **EPSDT Criteria not met: (Insert all EPSDT criteria not met)**

The clinical rationale used in making the Reconsideration Review decision will be provided in writing upon request. To request the clinical rational, please call **(Insert LME-MCO Telephone Number).**

**Authority of (Insert Name of LME-MCO)**

(**Insert Name of LME-MCO)** has the authority to make decisions about Medicaid services because we have a Contract with the North Carolina Medicaid agency pursuant to 42 C.F.R. Part 438. We can only approve services that are medically necessary. We base our decision to approve or deny a request for Medicaid services on 10A NCAC 25A .0201, found at <http://reports.oah.state.nc.us/ncac.asp>, the North Carolina State Plan for Medical Assistance, found at <http://www.ncdhhs.gov/dma/plan/index.htm>, Medicaid Clinical Coverage Policies, found at  [http://www.ncdhhs.gov/dma/mp/index.ht](http://www.ncdhhs.gov/dma/mp/index.htm)m, the North Carolina MH/I-DD/SA Health Plan Waiver and the NC Innovations Waiver, found at  [http://www.ncdhhs.gov/dma/waiver](http://www.ncdhhs.gov/dma/waiver/)/, and established Clinical Practice Guidelines, which can be found on our website at **(Insert LME-MCO Web Address).** If you don’t have Internet access or want us to send you a copy of these documents, please call **(Insert LME-MCO Telephone Number).**

For more information or detail on any of the above information, please contact the Appeals Department at **(Insert Name of LME-MCO**) at the number listed below.

You have the right to appeal (Insert Name of LME-MCO)’s decision by filing a request for a State Fair Hearing with the North Carolina Office of Administrative Hearings (OAH) no later than thirty (30) days after the mailing date of this Notice of Resolution. Please review the enclosed forms for additional information about the OAH State Fair Hearing.

***Si usted quiere apelar esta decisión, usted debe responder antes de 30 días a partir de la fecha de este aviso. Si necesita ayuda para entender este aviso, por favor llame al (Insert LME-MCO Telephone Number)*.**

Sincerely,

Appeals Department

**(Insert Name of LME-MCO)**

**(Insert Telephone Number)**

cc: **Provider**

**(Insert method of LME-MCO posting to provider)**

Enclosure: State Fair Hearing Information and Instructions

 State Fair Hearing Request Form